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ABSTRACT

The following issues are addressed in this paper: (1) blacks are significantly dependent on public general hospitals for their medical care; (2) public hospitals represent an important community resource to the black community; (3) there are a number of forces at work on public general hospitals to either close or to significantly reduce the number and types of services provided by them; and (4) effective strategies must be developed if public general hospitals are to survive. Data are provided to show that blacks have higher proportions of health problems and less access to utilization of physician services than whites. Data are also presented to show that besides representing an important medical resource, public hospitals represent a major source of employment for blacks. In addition, it is argued that the thrust to control hospital costs puts public general hospitals in a vulnerable position and that the black community must take a more active part on all political levels to insure the viability of these institutions. (Author/EB)

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THE FATE OF THE PUBLIC HOSPITAL: CONSEQUENCES FOR BLACK FAMILIES

by Robert B. Johnson

Presented to the National Urban League Conference on Black Families: A source of national strength.

November 3, 1977

I am pleased to have been asked to participate in this conference and especially to have an opportunity to present to you some thoughts I have about the topic, "The Fate of Public Hospitals: Consequences for Black Families."

I believe this is an extremely important topic that requires a great deal of discussion in and among members of the Black community if we are to insure the survival of public general hospitals. There are several themes that I will attempt to develop.

1) Blacks are significantly dependent on public general hospitals for our medical care.
2) That public general hospitals represent an important community resource to the Black community.
3) That there are a number of powerful forces at work on public general hospitals to either close or to significantly reduce the number and types of services provided by them.

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4) That effective strategies must be developed if public general hospitals are to survive.

Public general hospials are short-term acute care hospitals owned by state or local governments. They can be more easily thought of in four categories:

1) Large urban public general hospials.
2) Medium size public general hospitals located in smaller cities and suburban areas.
3) Hospitals owned by public universities.
4) Small hospitals located in nonurban areas, and owned by the local government.

In 1975 there were 1,761 public general hospitals which represented 30% of all community hospitals in the U.S. These 1,761 hospitals had 210,154 beds; had over seven (7) million admissions, which produced fifty four (54) millions patient days and experienced over fifty one (51) million outpatient visits annually.

For the purpose of this paper I will be talking primarily about public general hospitals in large urban areas even though many of my comments apply to all public general hospitals.

It is important that we continue to be reminded about the disparity between the health status of blacks and whites in this country.

The difference in statistical comparison between blacks and whites in the U.S. related to health indicies are legion. Nonwhite males born in 1970 could expect to live 6.7 years less than white makes born the same year, with nonwhite females expecting to live 6.2 years less than white females born the same year, and as with white females live longer than males by seven years.

In 1972 the infant mortality rate was 28.3 per 1,000 live births among nonwhites as compared to 15.8 per 1,000 live births among whites. It is not surprising that nonwhites have longer lengths of stay in hospitals for the same disease than whites.

	Average Length of Stay	
	Nonwhite	White
Infective and parasitic disease	16.1	8.9
Malignant neoplasms	17.5	15.3
Diabetes melitus	14.9	11.9
General Arteriosclerosis	27.6	17.2
Hypertensive heart disease	15.0	11.3

As a means of measuring utilization of health services, one indicator is the percentage of the population who sees a physician during the course of the year. In 1970 58 percent of Blacks and 70 percent of whites reported seeing a physician during the year. I am certain that this is a function of many factors including economics, availability of physicians and the relative priority given to routine health problems. In 1970 65 percent of low income families saw a physician during the year as compared to 67 percent of middle income and 71 percent of upper income families. One of the groups where there is a striking difference between Blacks and whites is among children under five (5) years of age.

	Male		Female	
	White	Nonwhite	White	Nonwhite
Under 5 yrs.	83.9	69.5	81.9	64.7

The purpose of this data is to clearly demonstrate that Blacks have significantly high proportions of health problems and less access to or utilization of physician services than whites. This should not come as a surprise to any one, however, a review of some of the reasons for this is important.

1) As a general rule, there are inadequate numbers of private practicing physicians in the inner cities of large urban areas where Blacks are generally concentrated.

2) Due to the lack of adequate health insurance Blacks must depend on public hospitals to receive their medical care.

3) Even where Blacks have medicaid, many private physicians would prefer not to care for medicaid recipients. In many cases medicaid does not reimburse the doctor at the same level as he re-receives from his private pay patients.

4) Blacks have established ongoing long term patterns of receiving their care from public hospitals and are comfortable in these familiar surroundings.

5) Even though I do not have the data I am certain that you will find a significantly larger percentage of Blacks using public general hospitals than our representation in the community where these hospitals are located.

In most communities the public general hospital has come to represent an important medical resource, which is not always recognized by the Black community. Not only does the public hospital represent a place where Blacks receive most of their

medical care, but it also represents a major source of employment. In 1976 over a half million personnel were employed in the 1700 PGH (1). Even though public general hospitals represent thirty (30) percent of all the community hospitals, twenty-two (22) percent of all of the acute care beds, twenty-one (21) percent of all of the admissions and twenty-seven (27) percent of all of the outpatient visits, almost thirty-seven (37) percent of all intern and residents are trained in public general hospitals. In 1975 the total expenditure in public hospitals was a staggering forty-six (46) billion dollars (1).

This large expenditure of funds represents a major collective resource which has not gone unnoticed by the larger community. Even though many public hospitals have been chronically under financed, the amount of money currently spent to provide services in public hospitals represents an important resource.

I will attempt to descrive the various forces that are currently acting upon public general hospitals and indicate the effect of their action. Public hospitals tend to be old physical facilities that do not meet current life safety code

standards. The cost of making capital improvements necessary to meet Life Safety Code Standards is expensive. The availability of capital money in most municipalities for such projects is very low. This situation represents one of the major shortcomings that has placed public general hospitals in a vulnerable position.

1) As a condition of participation in the medicare program, hospitals are required to be accredited by the Joint Commission on the Accreditation of Hospitals. Over the last three years the Joint Commission has increased the numbers of hospitals that it has rendered nonaccredited. Even though I do not have the data I would strongly suspect that there have been a greater number of PGH disaccredited proportionate to the number of private hospitals surveyed in this period.

2) In many states, local and state health departments act either on behalf of the Federal government or on the basis of State Health and Safety Statues to review voluntary, proprietary and public hospitals. In most states these agencies have the power to license hospitals and therefore to delicense. Many

of the agencies administer the states medicaid programs, including the setting of rates related to medicaid.

3) With the passage of the Comprehensive Health Planning legislation and more recently the passage of PL 93-641, the National Health Planning and Resources Act, the Federal government has brought to bear a wide range of pressures on public hospitals.

For example, there is a major thrust from the national level to control hospital cost, in part, through the elimination of under utilized hospital facilities. Traditionally, public general hospitals have had a lower percentage of occupancy than comparable voluntary hospitals. In 1975 the average occupancy rate in state and local governmental hospitals was 69.7% compared to 77.4% average occupancy rate in voluntary hospitals. The Federal government is contemplating a national guideline for general hospitals requiring hospitals to maintain an average annual occupancy rate for area hospitals of at least 80%. However, seldom is it pointed out that most voluntary

hospital admissions are elective (i.e. planned) and that most public hospital admissions are emergency i.e. unplanned and, therefore, it is easier to insure a predicably higher occupancy rate in a hospital where most admissions are planned. Further, it has been suggested that maternity units in metropolitan areas should handle at least 2,000 deliveries a year. If we see increase pressure to close down obstetrical units in public hospitals that are under this level of utilization, you can be sure of two things:

a) There will be no national provisions for paying for the maternity care of the medical indigent population currently using public hospitals that are not covered by medicaid.

b) The same weight of pressure will not be applied to voluntary hospitals to close underutilized obstetrical units and consolidate them within the public hospitals.

4) Federal and private insurance mechanisms have provisions which either directly or indirectly require accreditation from the Joint Commission on Accreditation of Hospitals

to make a hospital eligible for reimbursement. It could easily happen that through loss of JCAH status a public hospital, already tethering on the verge of financial collapse, could be rendered insolvent without JCAH accreditation.

5) As I mentioned earlier, public general hospitals provide the training for 37 percent of all U.S. interns and residents. Even though JCAH accreditation is not an absolute requirement for an approved training program, it is certainly highly stressed. Very few public general hospitals that have intern and residency training programs could survive without them. In most public general hospitals that have training programs, a large percent of direct patient care is provided by interns and residents. Public Law 94-484, Health Professions Educational Assistance Act of 1976 has also intensified the pressure on public general hospitals by restricting the percentage of Foreign Medical Graduates in the U.S. training programs. Most public hospitals have a high percentage of foreign medical graduates in their training programs.

Even though the objective of the bill is to increase the number of American medical graduates trained in the U.S. hospitals, the short-term impact could be significant so as to render public general hospitals unable to maintain viable post graduate trainee programs; thereby, unable to maintain sufficient medical manpower to continue to provide the level of care required in public general hospitals.

6) The last major area I see that negatively impacts on the survival of public hospitals is the local media coverage of such hospital and the resulting public attitude that emerges. I am sure the trend of critical coverage of public hospitals and public institutions in general did not come about because of the emergence of black control in urban areas. However, I would contend that it is a force that must be viewed with great concern when the attacks only serve to undermine public confidence and not to inform. I believe that it has become chic in many black communities especially among middle class Blacks to join in either unwittingly or because it has become the in thing to do, to become unnecessarily critical of black controlled or black run institutions. Let me hasten to

say that I am not among those that believe that we should not criticize our own because I believe that such a policy would lead very quickly to institutionalizing mediocrity and incompetence. However, we must be careful not to become a part of the problem rather than the solution.

In summation let me list what I believe to be the outline of a strategy for survival.

1) We as health professionals must take a leadership role in bringing about a level of community sensitivity and sophistication to allow us to recognize, understand and deal effectively with the obvious, as well as subtle issues. This means taking an active part in community affairs, being involved in all aspects of local health politics and more importantly interacting with the Black community on all issues.

2) We must analyze and define the importance of National Health Insurance on our institutions. We must become effective in lobbying for those federal health programs and policies that will insure the long-term viability of our institutions.

Many people believe that if public hospitals can survive until some form of National Health Insurance is enacted, provided that we continue to prepare our institutions to be first rate medical institutions, we can be competitive within the community of hospitals when all citizens are covered by some form of third party coverage.

3) We must encourage the community to become involved in the governance of public hospitals. Through effective reorganizations of public hospitals making them public benefit corporations, many objectives can be realized that can help insure our viability. Community control can have real relevance only when it is accompanied by real power, authority, and responsibility.

4) As health professionals, we must take the lead in bringing about regionalization of services and developing well managed, cost effective hospitals. If we don't take the lead in this area, we will find that the forces that would like to eliminate public general hospitals will shape the direction and destiny of our hospitals, having an even greater impact on the health status of the Black community.

We have a challenge here, either we become an alert, sophisticated and enlightened community or we will find that those institutions that have a major impact on our lives are out of our control. We must come to recognize our self interest. Unless we have control over the basic institutions that insure our health, safety and welfare, we will always be a people whose destiny and survival is dependent on others.